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Editorial: What becomes of the whistleblowers?

Alternately praised and damned, constructed as both hero and villain, courageous and cowardly: whistleblowers are people who disclose improper practices to people or bodies in the hope of stimulating action and positive change (Mesmer-Magnus & Viswesvaran 2005). Berry (2004:1) asserts that:

> Whistleblowing is an avenue for maintaining integrity by speaking one's truth about what is right and what is wrong. It is a strategy for asserting rights, protecting interests, influencing justice, and righting wrongs. Whistleblowing is the voice of conscience.

However, noble as its intent might be, whistleblowing can carry immense personal and professional cost. Martin and Rifkin (2004) have noted that, as an act of dissent, whistleblowing is seldom a success and is usually a course that is disastrous to those who blow the whistle. Whistleblowers may be cast as 'enemies of the institution' (Rhodes & Strain 2004:35), and positioned as 'disaffected, antisocial and incompetent' (Faunce *et al.* 2004:41). The (relatively scant) literature on the topic suggests that the act of whistleblowing is a devastating and possibly career ending event that can attract a range of hostile and retaliatory consequences for the whistleblower including organisational retribution (Martin & Rifkin 2004) and loss of social and peer support (Attree 2007). There are many documented forms of reprisal including pillorying, ostracism, humiliation and other exclusionary practices aimed at isolating and marginalising the whistleblower (Berry 2004, Faunce *et al.* 2004). Mental illness and suicide are among outcomes described as commonly resulting from whistleblowing acts (Faunce *et al.* 2004:41).

Clearly, as a course of action, whistleblowing is certainly not to be taken lightly. It involves far more than simply speaking out to right a perceived wrong. Whistleblowing involves a moral burden – of holding information that may not have been actively sought, or wanted. It likely involves conflicting emotions, the fear of loss of workplace relationships and possible confusion around notions of betrayal and disloyalty. It may come after a period of uncertainty, in a context of deep distress and increasing alienation, as (perhaps repeated) attempts to draw attention to the issues using approved organisational processes are unsuccessful. It may carry with it a sense of disillusionment, as belief in previously trusted organisational processes disintegrates.

Internal whistleblowing – using approved 'in-house' mechanisms – while undoubtedly stressful and anxiety provoking can be assumed to carry less risk and ramification than external whistleblowing – that which involves going to agencies external to an organisation (Firtko & Jackson 2005). However, when considering the nature of an outside agency that can be used in whistleblowing, none would carry more personal risk than use of the media. Those using the media certainly may get their 15 minutes of fame, but often with personally catastrophic results. Therefore, given its inherent personal risk, what is it that makes people go outside their organisations and approach external agencies such as the media?

Lack of responsive and effective alternatives are cited as reasons. In an analysis of four whistleblower generated hospital inquiries in Australia, Dunbar *et al.* (2007) identified two features common to all four cases. These were a lack of policy and process for examining accusations of poor practice, and a belief on the part of the whistleblowers that the matters of concern were not adequately scrutinised internally. In an exploration of factors impacting nurses' decisions to raise concerns about practice issues, Attree (2007) concluded that concern about detrimental personal consequences, coupled with little confidence in systems for raising concerns were disincentives to reporting. In the situation where there is little confidence in organisational processes, nurses are left with three options. These are: to go ahead and avail themselves of the very processes they have little confidence in; to remain silent and maintain the status quo; or, to go outside the organisation.

In an ideal world, there would be no need for whistleblowing. However, we do not live in an ideal world, and the pressures and vulnerability of health care organisations are such that whistleblowing is not likely to decrease. There are a number of factors that can contribute to the vulnerability of health care organisations, including historical factors influencing the ways the workforce are socialised, and the climate of confidentiality within which many operational matters are conducted (Rhodes & Strain 2004). Furthermore, the health sector is caught in an uneasy tension between the imperative to consistently provide a certain level and standard of care, and the very real resource constraints that can jeopardise the ability to provide care to a standard that satisfies consumers and health professional staff. These factors can work together to foster a 'culture of concealment' (Dunbar *et al.* 2007:81) in which it is possible for wrongdoing to continue unchallenged for quite some time.

Though many health and other large organisations have policies in place

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urging employees to disclose improprieties, inappropriate behaviour or breaches of accepted practice, this is not enough. Thought needs to be given to how then to manage the issue and initiate investigative processes, whilst ensuring moral and procedural fairness to any accused party and adequate protection for those who blow the whistle. Our tasks are twofold. First, to contribute actively to moral, ethical organisational cultures within which mechanisms to raise concerns are effective and responsive and, second, to work to ensure the safety and well being of those who feel compelled to call attention to perceived wrongdoing. Berry (2004) asserts that organisations should actively develop cultures that will promote and aid efficacious whistleblowing and identifies characteristics to facilitate this. These she names as:

- Vigilance – being in a position to become aware of violations;
- Engagement – a state of genuine connection with the organisation;
- Credibility – belief in organisational integrity;
- Accountability – sense of duty or moral responsibility to report violations;
- Empowerment – a belief in the power to effect positive change;
- Courage – to face possible retaliatory actions; and
- Options – the existence of clear and proper channels within which concerns can be raised.

It is important that health professionals feel safe to disclose any perceived breaches of care or other wrongdoing, especially when they believe there is any actual or potential threat to patients or colleagues. Indeed, time and again, whistleblowing has been the catalyst for a course of events that has eventually resulted in improved processes, clearer protocols and greater safety for health service consumers as well as health professionals. In these cases, the initial whistleblowers acted with courage and altruistic intent. It is not acceptable that, after doing so, these people are left to limp into a corner, career in tatters, jobless, friendless and alone.

Who knows which of us could one day find ourselves caught in the whistleblower dilemma – carrying the moral burden of knowledge (or honest belief) of wrongdoing, and then having to decide what to do with the information? Perhaps deciding to raise concerns using organisational processes, only to feel these concerns are trivialised. Feeling then that the only option is to go outside the organization; and then, to find oneself alone, with little support to draw on and against the might of an organisation.

Currently, whistleblowing represents a professional dilemma and a personal disaster. As a professional group, we need to scrutinise and theorise it, and develop effective strategies to manage information about professional or organisational wrongdoing that do not unfairly taint individuals or organisations, or sacrifice the very people who seek to right wrongs and initiate positive change.

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